		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038083

Facility Name: Lexington of LaGrange

Address: 4735 Willow Springs Road (Number) LaGrange (City) 60525 (Zip Code)

County: Cook

Telephone Number: (708) 352-6900 **Fax #** (708) 482-0239

IDPA ID Number: 363835751001

Date of Initial License for Current Owners: 07/31/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,894	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,894	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,583	8,514	7,378	33,475	8
9	SNF/PED					9
10	ICF	3,074	1,253	206	4,533	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,657	9,767	7,584	38,008	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.27%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/31/92

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 109 and days of care provided 6,568

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	223,196	14,244	8,030	245,470		245,470		245,470			1
2	Food Purchase		151,371		151,371		151,371	(7,402)	143,969			2
3	Housekeeping	185,485	19,883		205,368		205,368	158	205,526			3
4	Laundry	33,351	11,381		44,732		44,732	(7,475)	37,257			4
5	Heat and Other Utilities			141,749	141,749		141,749	1,801	143,550			5
6	Maintenance	24,242		67,386	91,628		91,628	23,149	114,777			6
7	Other (specify):* **Allocated Benefits**							2,605	2,605			7
8	**TOTAL General Services**	466,274	196,879	217,165	880,318		880,318	12,836	893,154			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,931,215	90,952	11,650	2,033,817		2,033,817	30,432	2,064,249			10
10a	Therapy			525,336	525,336		525,336		525,336			10a
11	Activities	165,139	10,853	3,761	179,753		179,753		179,753			11
12	Social Services	27,465		2,302	29,767		29,767		29,767			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Allocated Benefits**							3,680	3,680			15
16	**TOTAL Health Care and Programs**	2,123,819	101,805	561,049	2,786,673		2,786,673	34,112	2,820,785			16
	C. General Administration											
17	Administrative	100,395		529,552	629,947		629,947	(478,334)	151,613			17
18	Directors Fees											18
19	Professional Services			45,089	45,089		45,089	6,115	51,204			19
20	Dues, Fees, Subscriptions & Promotions			14,365	14,365		14,365	(53)	14,312			20
21	Clerical & General Office Expenses	171,130	27,688	12,538	211,356		211,356	143,744	355,100			21
22	Employee Benefits & Payroll Taxes			385,686	385,686		385,686	7,402	393,088			22
23	Inservice Training & Education			1,880	1,880		1,880		1,880			23
24	Travel and Seminar			1,812	1,812		1,812	1,966	3,778			24
25	Other Admin. Staff Transportation			337	337		337	5,056	5,393			25
26	Insurance-Prop.Liab.Malpractice			135,246	135,246		135,246	2,251	137,497			26
27	Other (specify):* **Allocated Benefits**							22,199	22,199			27
28	**TOTAL General Administration**	271,525	27,688	1,126,505	1,425,718		1,425,718	(289,654)	1,136,064			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,861,618	326,372	1,904,719	5,092,709		5,092,709	(242,706)	4,850,003			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of LaGrange #0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			37,004	37,004		37,004	91,463	128,467			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,072	1,072		1,072	164,994	166,066			32
33	Real Estate Taxes							215,693	215,693			33
34	Rent-Facility & Grounds			811,011	811,011		811,011	(810,285)	726			34
35	Rent-Equipment & Vehicles			3,157	3,157		3,157	1,531	4,688			35
36	Other (specify):*											36
37	**TOTAL Ownership**			852,244	852,244		852,244	(336,604)	515,640			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		185,628		185,628		185,628		185,628			39
40	Barber and Beauty Shops			22,732	22,732		22,732		22,732			40
41	Coffee and Gift Shops			5,705	5,705		5,705		5,705			41
42	Provider Participation Fee			59,842	59,842		59,842		59,842			42
43	Other (specify):* Nonallowable Costs			200,168	200,168		200,168	(200,168)				43
44	**TOTAL Special Cost Centers**		185,628	288,447	474,075		474,075	(200,168)	273,907			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,861,618	512,000	3,045,410	6,419,028		6,419,028	(779,478)	5,639,550			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(7,475)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,254)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(794)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(168,481)	43		24
25	Fund Raising, Advertising and Promotional	(9,728)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,500)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule A	(19,120)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (219,552)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(559,926)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (559,926)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (779,478)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lagrange
Provider # 0038083
1/1/04 - 12/31/04

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(2,981)	19
Nonallowable Chamber of Commerce dues	(525)	20
Miscellaneous income offset	(237)	21
Disallow unclaimed property costs	(626)	21
Real estate tax refund costs	215	33
Disallow radiology	(8,286)	43
Disallow laboratory	(6,160)	43
Disallow personal item replacement	(19)	43
Disallow out of period legal fees	(501)	19
Total	(19,120)	

See Accountants' Compilation Report

Lexington of LaGrange

ID# 0038083

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	158	0	0	0	0	0	0	0	0	158	3
4	Laundry	(7,475)	0	0	0	0	0	0	0	0	0	0	(7,475)	4
5	Heat and Other Utilities	0	0	1,801	0	0	0	0	0	0	0	0	1,801	5
6	Maintenance	0	0	23,149	0	0	0	0	0	0	0	0	23,149	6
7	Other (specify):*	0	0	2,605	0	0	0	0	0	0	0	0	2,605	7
8	**TOTAL General Services**	(7,475)	0	27,713	0	0	0	0	0	0	0	0	20,238	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	30,432	0	0	0	0	0	0	0	0	30,432	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	3,680	0	0	0	0	0	0	0	0	3,680	15
16	**TOTAL Health Care and Programs**	0	0	34,112	0	0	0	0	0	0	0	0	34,112	16
	C. General Administration													
17	Administrative	0	0	51,218	(529,552)	0	0	0	0	0	0	0	(478,334)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,932	9,329	0	0	0	0	0	0	0	0	13,261	19
20	Fees, Subscriptions & Promotions	0	0	472	0	0	0	0	0	0	0	0	472	20
21	Clerical & General Office Expenses	0	72	144,535	0	0	0	0	0	0	0	0	144,607	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,966	0	0	0	0	0	0	0	0	1,966	24
25	Other Admin. Staff Transportation	0	0	0	5,056	0	0	0	0	0	0	0	5,056	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,251	0	0	0	0	0	0	0	2,251	26
27	Other (specify):*	0	0	0	22,199	0	0	0	0	0	0	0	22,199	27
28	**TOTAL General Administration**	0	4,004	207,520	(500,046)	0	0	0	0	0	0	0	(288,522)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,475)	4,004	269,345	(500,046)	0	0	0	0	0	0	0	(234,172)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of LaGrange # 0038083 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	76,181	0	15,282	0	0	0	0	0	0	0	91,463	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,254)	172,063	0	185	0	0	0	0	0	0	0	164,994	32
33	Real Estate Taxes	0	211,011	0	803	0	0	0	0	0	0	0	211,814	33
34	Rent-Facility & Grounds	0	(811,011)	0	726	0	0	0	0	0	0	0	(810,285)	34
35	Rent-Equipment & Vehicles	0	0	0	1,531	0	0	0	0	0	0	0	1,531	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,254)	(351,756)	0	18,527	0	0	0	0	0	0	0	(340,483)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(185,703)	0	0	0	0	0	0	0	0	0	0	(185,703)	43
44	**TOTAL Special Cost Centers**	(185,703)	0	0	0	0	0	0	0	0	0	0	(185,703)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(200,432)	(347,752)	269,345	(481,519)	0	0	0	0	0	0	0	(760,358)	45

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of LaGrange		
See attached Schedule B		See attached Schedule B		Limited Partnership	LaGrange	Real Estate ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, LLC	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 811,011	Sambell of LaGrange Limited Partnership	**	$	$ (811,011)	1
2	V	19	Professional fees		Sambell of LaGrange Limited Partnership	**	3,932	3,932	2
3	V	21	Bank charges		Sambell of LaGrange Limited Partnership	**	72	72	3
4	V	30	Depreciation		Sambell of LaGrange Limited Partnership	**	76,181	76,181	4
5	V	32	Interest expense		Sambell of LaGrange Limited Partnership	**	170,286	170,286	5
6	V	32	Amortization of mortgage costs		Sambell of LaGrange Limited Partnership	**	1,777	1,777	6
7	V	33	Property taxes		Sambell of LaGrange Limited Partnership	**	211,011	211,011	7
8	V								8
9	V								9
10	V				** The owners of Lexington Health Care Center of LaGrange, Inc. own 100%				10
11	V				of Sambell of LaGrange Limited Partnership				11
12	V								12
13	V								13
14	Total			$ 811,011			$ 463,259	$ * (347,752)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lagrange Inc.
Provider # 0038083
1/1/04 - 12/31/04

Schedule B

VII. Related Parties
Owners

Name	Ownership %
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 158	$ 158	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	1,713	1,713	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	45	45	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	43	43	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	21,543	21,543	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	1,606	1,606	20
21	V	7	Management allocation - employee benefits		Royal Management Corp.	**	2,605	2,605	21
22	V	10	Management allocation - salaries		Royal Management Corp.	**	30,432	30,432	22
23	V	15	Management allocation - employee benefits		Royal Management Corp.	**	3,680	3,680	23
24	V	17	Management allocation - salaries		Royal Management Corp.	**	51,218	51,218	24
25	V	19	Computer consultant & supplies		Royal Management Corp.	**	5,734	5,734	25
26	V	19	Professional fees		Royal Management Corp.	**	3,595	3,595	26
27	V	20	Dues & subscriptions		Royal Management Corp.	**	424	424	27
28	V	20	Licenses, permits & inspections		Royal Management Corp.	**	11	11	28
29	V	20	Advertising - help wanted		Royal Management Corp.	**	37	37	29
30	V	21	Management allocation - salaries		Royal Management Corp.	**	132,358	132,358	30
31	V	21	Bank charges		Royal Management Corp.	**	1,053	1,053	31
32	V	21	Office supplies & printing		Royal Management Corp.	**	4,473	4,473	32
33	V	21	Postage		Royal Management Corp.	**	1,832	1,832	33
34	V	21	Telephone		Royal Management Corp.	**	4,819	4,819	34
35	V	24	Travel & seminar		Royal Management Corp.	**	1,966	1,966	35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 269,345	$ * 269,345	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 5,056	$ 5,056	15
16	V	26	Insurance general		Royal Management Corp.	**	2,251	2,251	16
17	V	27	Management allocation - employee benefits		Royal Management Corp.	**	22,199	22,199	17
18	V	30	Depreciation - vehicles		Royal Management Corp.	**	1,640	1,640	18
19	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	3,556	3,556	19
20	V	30	Depreciation - equipment		Royal Management Corp.	**	10,086	10,086	20
21	V	32	Interest		Royal Management Corp.	**	185	185	21
22	V	33	Property taxes		Royal Management Corp.	**	803	803	22
23	V	34	Rent expense		Royal Management Corp.	**	726	726	23
24	V	35	Equipment rental		Royal Management Corp.	**	1,531	1,531	24
25	V	17	Management fees	529,552	Royal Management Corp.	**		(529,552)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 529,552			$ 48,033	$ * (481,519)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	2	4%	Salary	$ 17,044	L 17, C 7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	1	2%	Salary	12,174	L 17, C 7	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	3	6%	Salary	12,174	L 17, C 7	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	3%	Salary	2,965	L 17, C 7	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	3	6%	Salary	6,861	L 17, C 7	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 51,218		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Royal Management Corp

Schedule C

1/1/04 - 12/31/04

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	19,211	26,895	19,211	4,679	10,827	80,823
Lexington Health Care Center of Chicago Ridge, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Elmhurst, Inc.	16,754	23,455	16,754	4,081	9,442	70,486
Lexington Health Care Center of Lake Zurich, Inc.	23,790	33,306	23,790	5,795	13,408	100,089
Lexington Health Care Center of Lombard, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Orland Park, Inc.	30,154	42,219	30,154	7,346	16,995	126,868
Lexington Health Care Center of Schaumburg, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Streamwood, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Wheeling, Inc.	24,684	34,557	24,684	6,012	13,912	103,849
Total	214,669	300,536	214,669	52,289	120,984	903,147

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	743,346	10	$ 2,938	$	39,894	$ 158	1
2	5	Utilities - gas & electric	Bed Days	743,346	10	31,920		39,894	1,713	2
3	5	Utilities - water & sewer	Bed Days	743,346	10	846		39,894	45	3
4	5	Utilities - maintenance office	Bed Days	743,346	10	808		39,894	43	4
5	6	Management allocation - salaries	Bed Days	743,346	10	401,410	401,410	39,894	21,543	5
6	6	Repairs & maintenance	Bed Days	743,346	10	29,930		39,894	1,606	6
7	7	Management allocation - employe	Bed Days	743,346	10	48,540		39,894	2,605	7
8	10	Management allocation - salaries	Bed Days	743,346	10	567,037	567,037	39,894	30,432	8
9	15	Management allocation - employe	Bed Days	743,346	10	68,569		39,894	3,680	9
10	17	Management allocation - salaries	Bed Days	743,346	10	954,365	954,365	39,894	51,218	10
11	19	Computer consultant & supplies	Bed Days	743,346	10	106,838		39,894	5,734	11
12	19	Professional fees	Bed Days	743,346	10	66,993		39,894	3,595	12
13	20	Dues & subscriptions	Bed Days	743,346	10	7,893		39,894	424	13
14	20	Licenses, permits & inspections	Bed Days	743,346	10	212		39,894	11	14
15	20	Advertising - help wanted	Bed Days	743,346	10	698		39,894	37	15
16	21	Management allocation - salaries	Bed Days	743,346	10	2,466,223	2,466,223	39,894	132,358	16
17	21	Bank charges	Bed Days	743,346	10	19,618		39,894	1,053	17
18	21	Office supplies & printing	Bed Days	743,346	10	83,348		39,894	4,473	18
19	21	Postage	Bed Days	743,346	10	34,142		39,894	1,832	19
20	21	Telephone	Bed Days	743,346	10	89,797		39,894	4,819	20
21	24	Travel & seminar	Bed Days	743,346	10	36,624		39,894	1,966	21
22										22
23										23
24										24
25	TOTALS					$ 5,018,749	$ 4,389,035		$ 269,345	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	743,346	10	$ 94,217	$	39,894	$ 5,056	1
2	26	Insurance general	Bed Days	743,346	10	41,943		39,894	2,251	2
3	27	Management allocation - employe	Bed Days	743,346	10	413,634		39,894	22,199	3
4	30	Depreciation - vehicles	Bed Days	743,346	10	30,557		39,894	1,640	4
5	30	Depreciation - leasehold improv.	Bed Days	743,346	10	66,255		39,894	3,556	5
6	30	Depreciation - equipment	Bed Days	743,346	10	187,937		39,894	10,086	6
7	32	Interest	Bed Days	743,346	10	3,446		39,894	185	7
8	33	Property taxes	Bed Days	743,346	10	14,963		39,894	803	8
9	34	Rent expense	Bed Days	743,346	10	13,526		39,894	726	9
10	35	Equipment rental	Bed Days	743,346	10	28,527		39,894	1,531	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 895,005	$		$ 48,033	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						$	$			$	1
2	Services II, LLC	X		Mortgage	$22,735.00	12/29/98	2,990,000	2,475,454	12/29/2008	0.0675	170,286	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank, N.A.		X	Line of Credit	Various	12/1/02	500,000	100,000	05/31/05	Prime	1,072	6
7	Partner Loans	X		Working Capital	Various	11/26/03	1,330,000	1,330,000	Demand	0.0425		7
8												8
9	TOTAL Facility Related				$22,735.00		$ 4,820,000	$ 3,905,454			$ 171,358	9
	B. Non-Facility Related*											
10								Amortization of loan costs			1,777	10
11								Interest income offset			(7,254)	11
12								Allocated from management company			185	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,292)	14
15	TOTALS (line 9+line14)						$ 4,820,000	$ 3,905,454			$ 166,066	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$ 210,000	1
	Allocated from Management Company	803	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 205,441	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,756)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 216,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 3,879	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 645 For 1997 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (430)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 215,693	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	196,475	8
	2000	208,552	9
	2001	220,342	10
	2002	198,271	11
	2003	205,441	12

2003 Taxes:	205,441
Est. Increase	1.05
	215,713
Use	216,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of LaGrange COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

CONTACT PERSON REGARDING THIS REPORT Ms. Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-08-207-017-000	Land and building	$ 140,065.00	$ 140,065.00
2.	18-08-207-018-001	Land and building	$ 65,376.00	$ 65,376.00
3.	Royal Managament Corp. (Samvest of Lombard II)		$	$
4.	05-01-202-019	Land and building	$ 187,600.00	$ 803.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 393,041.00	$ 206,244.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,992 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	40,000	1991	$ 500,000	1
2	Allocated from Management Company			8,605	2
3	TOTALS	40,000		$ 508,605	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1992	1992	$ 2,661,448	$	35	$ 76,040	$ 76,040	$ 950,516	4
5	10		1995	1995	79,363	7,936	10	7,936		75,394	5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1992	1,152		20	58	58	721	9
10	Building Improvements			1992	2,714		31			2,714	10
11	Building Improvements			1993	2,901		35	83	83	953	11
12	Leasehold Improvements			1994	6,402	213	10	213		6,295	12
13	Leasehold Improvements - Corner Guards			1996	2,195	219	10	219		1,866	13
14	Wiring			1998	3,378	338	10	338		2,196	14
15	Resurface & Restripe Parking Lot			1998	3,753	375	10	375		2,439	15
16	Lobby Tile			1998	19,488	1,949	10	1,949		12,018	16
17	Resurface & Restripe Parking Lot			2000	1,997	200	10	200		899	17
18	Automatic Door			2000	1,300	130	10	130		585	18
19	Kitchen Rehab			2001	1,441	144	10	144		504	19
20	Infrared curtains for elevator			2001	3,000	300	10	300		1,050	20
21	Dining room, resident rooms, and corridors renovation			2002	150,083	7,505	20	7,505		15,633	21
22	Elevator upgrade			2002	5,399	540	10	540		1,440	22
23	Air conditioner compressor			2003	9,218	922	10	922		1,306	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Land improvements - management company	2002	$ 13,562	$	15	$ 897	$ 897	$ 2,637	37
38	Building - management company	2002	105,510		40	2,580	2,580	7,693	38
39	HVAC, electrical, security system - management company	2003	1,046		30	71	71	99	39
40	Key card system - management company	2004	164		20	8	8	8	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,075,514	$ 20,771		$ 100,508	$ 79,737	$ 1,086,966	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 100,654	$ 14,088	$ 14,088	$	3-10 years	$ 63,463	71
72	Current Year Purchases	38,617	2,145	2,145		5-10 years	2,145	72
73	Fully Depreciated Assets	263,797					263,797	73
74	Allocated from Management Company	101,206		10,086	10,086		42,269	74
75	TOTALS	$ 504,274	$ 16,233	$ 26,319	$ 10,086		$ 371,674	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Management Company			21,180		1,640	1,640		14,553	79
80	TOTALS			$ 21,180	$	$ 1,640	$ 1,640		$ 14,553	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,109,573	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,004	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,467	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 91,463	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,473,193	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Reception area rehab	$ 6,232	92
93	10 bed addition	1,278,181	93
94			94
95		$ 1,284,413	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from management company				726			6
7	TOTAL				$ 726 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 4,688 Description: Copier - $2,708; Fax machine - $270; Postage meter - $ 179; Allocated from management company - $1,531
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	3,649	$ 225,815	$	3,649	$ 225,815	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		133	13,396		133	13,396	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		4,359	286,125		4,359	286,125	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				185,628		185,628	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	8,141	$ 525,336	$ 185,628	8,141	$ 710,964	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 185,665	$ 322,938	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 380,000)	682,952	682,952	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,624	87,624	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow		64,041	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 956,241	$ 1,157,555	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,993	3,993	12
13	Land		508,605	13
14	Buildings, at Historical Cost		2,664,349	14
15	Leasehold Improvements, at Historical Cost	287,017	411,165	15
16	Equipment, at Historical Cost	187,707	525,454	16
17	Accumulated Depreciation (book methods)	(235,668)	(1,473,193)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Construction in progr	6,232	1,284,413	22
23	Other(specify): Unamortized loan costs		24,871	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 249,281	$ 3,949,657	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,205,522	$ 5,107,212	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 233,768	$ 233,768	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,000	1,430,000	29
30	Accrued Salaries Payable	274,024	274,024	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,329	1,329	31
32	Accrued Real Estate Taxes(Sch.IX-B)		216,000	32
33	Accrued Interest Payable		13,924	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	152,264	69,868	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 761,385	$ 2,238,913	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,475,454	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,475,454	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 761,385	$ 4,714,367	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 444,137	$ 392,845	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,205,522	$ 5,107,212	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Lagrange, Inc.
Provider # 0038083
1/1/04 - 12/31/04

Schedule E

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued Rent	82,396	
Accrued management fees	20,941	20,941
Accrued 401 (k) contribution	15,428	15,428
Other accrued expenses	33,499	33,499
Total line 36	152,264	69,868

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Investment in Lexington Financial Services II, LLC.	40
Vending machine commission	406
Miscellaneous income	237
Total line 28	683

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 744,966	1
2	Restatements (describe):		2
3	**Post closing entries**	(64,569)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 680,397	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	528,740	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(765,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (236,260)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 444,137	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,138,474	1
2	Discounts and Allowances for all Levels	(561,952)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,576,522	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	955,008	6
7	Oxygen	3,031	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 958,039	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,922	12
13	Barber and Beauty Care	27,414	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	14	15
16	Rental of Facility Space		16
17	Sale of Drugs	262,288	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,852	19
20	Radiology and X-Ray	10,977	20
21	Other Medical Services	75,328	21
22	Laundry	7,475	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 405,270	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,254	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,254	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	683	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 683	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,947,768	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	880,318	31
32	Health Care	2,786,673	32
33	General Administration	1,425,718	33
	B. Capital Expense		
34	Ownership	852,244	34
	C. Ancillary Expense		
35	Special Cost Centers	414,233	35
36	Provider Participation Fee	59,842	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,419,028	40
41	**Income before Income Taxes (line 30 minus line 40)****	528,740	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 528,740	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity files a cash basis return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,885	1,988	$ 87,758	$ 44.14	1
2	Assistant Director of Nursing	61	273	7,653	28.03	2
3	Registered Nurses	22,941	24,279	709,727	29.23	3
4	Licensed Practical Nurses	14,950	16,248	368,974	22.71	4
5	Nurse Aides & Orderlies	59,289	63,069	694,821	11.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,275	4,721	62,282	13.19	8
9	Activity Director	2,052	2,108	35,155	16.68	9
10	Activity Assistants	12,279	13,089	129,984	9.93	10
11	Social Service Workers	1,776	2,134	27,465	12.87	11
12	Dietician					12
13	Food Service Supervisor	2,019	2,289	46,720	20.41	13
14	Head Cook	1,260	1,313	15,385	11.72	14
15	Cook Helpers/Assistants	11,689	12,483	98,846	7.92	15
16	Dishwashers	9,181	9,642	62,245	6.46	16
17	Maintenance Workers	1,910	2,010	24,242	12.06	17
18	Housekeepers	24,388	26,451	185,485	7.01	18
19	Laundry	4,750	5,082	33,351	6.56	19
20	Administrator	1,834	2,313	100,395	43.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,218	12,131	171,130	14.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,757	201,623	$ 2,861,618 *	$ 14.19	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	144	$ 8,030	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant	19	1,070	L10, C3	37
38	Nurse Consultant	3	405	L10, C3	38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	78	3,761	L11, C3	44
45	Social Service Consultant	51	2,302	L12, C3	45
46	Other(specify)				46
47	Rehabcare Consultant	1	69	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	296	$ 34,837		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Deborah Morris	Administrator	0.00%	$ 100,395
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 100,395

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 529,552
TOTAL (agree to Schedule V, line 17, col. 3)	$ 529,552
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Avail Corporation	Accounting	$ 172
Altschuler, Melvoin & Glasser LLP	Accounting	15,226
American Express Tax & Bus Srv	Accounting	4,152
Grabowski Law Center	Collections	2,981
Scott & Krause	Bond Consulting	228
Katten Muchin Zavis and Rosenman	Legal	736
Personnel Planners	U/C Consulting	1,204
James Samatas	Legal	100
Sachnoff & Weaver	Legal	9,129
Carol Jeschke	Staffing Consultant	756
See attached Schedule F		10,405
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 45,089

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,551
Unemployment Compensation Insurance	18,576
FICA Taxes	211,957
Employee Health Insurance	82,321
Employee Meals	7,402
Illinois Municipal Retirement Fund (IMRF)*	
401 (k) Contributions	12,339
Other Employee Benefits	10,021
Life Insurance	2,921
TOTAL (agree to Schedule V, line 22, col.8)	$ 393,088

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,560
Health Care Worker Background Check	
(Indicate # of checks performed 80)	800
Miscellaneous licenses & permits	1,005
Miscellaneous dues & subscriptions	475
Allocated from Management Company	472
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,312

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,812
Allocated from Management Company	1,966
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,778

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Lagrange, Inc.
Provider # 0038083
1/1/04 - 12/31/04

Schedule F

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Advanced Answers on Demand, Inc.	Computer Consulting	2,652
National Datacare Coprporation	Computer Consulting	633
AdminaStar	Computer Consulting	396
Gigatrend	Computer Consulting	195
Information Controls, Inc.	Computer Consulting	867
eHealth Solutions	Computer Consulting	3,600
Lanac	Computer Consulting	792
Covad Communications	Computer Consulting	1,270
Total, Other Professional Services		10,405
Total, Agrees to Schedule V, Line 19, Column 3		45,089
Allocated from management co.		
American Express Tax & Business Services	Accounting	162
Altschuler, Melvoin and Glasser LLP	Accounting	260
Account Temps	Accounting	444
Avail Corporation	Accounting	13
Doris Fischer	Medicaid Billing Consultant	1,143
Gene Whitehorn	Medicaid Billing Consultant	395
Susan Parker, LCSW	DNR Consulting	6
Personnel Planners	U/C Consulting	6
Gilson, Labus and Silverman	Accounting	135
James Samatas	Legal	19
Sachnoff and Weaver	Legal	532
ING / Pension Administrators	401 (k) Administration	466
Eric Haider	Consulting	14
Various	Computer Consulting	5,734
Allocated from building partnership		
James Samatas	Filing and recording fees	268
Dennis W. Hetler & Associates PC	Real Estate Tax appeal	3,664
Nonallowable legal fees		
Grabowski Law Center	Legal-collection fees	(2,981)
Disallow out of period legal fees		
Katten, Muchin, Zavis & Rosenman	Legal - out of period	(501)
Reclassifications		
Dennis W. Hetler & Associates PC	Real Estate Tax appeal	(3,664)
Total, Agrees to Schedule V, Line 19, Column 8		51,204

See accountants' compilation report.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$ N/A	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **33,059** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **59,842**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **7,402** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	223,196	14,244	8,030	245,470	0	245,470	0	245,470
2. Food Purchase	0	151,371	0	151,371	0	151,371	-7,402	143,969
3. Housekeeping	185,485	19,883	0	205,368	0	205,368	158	205,526
4. Laundry	33,351	11,381	0	44,732	0	44,732	-7,475	37,257
5. Heat and Other Utilities	0	0	141,749	141,749	0	141,749	1,801	143,550
6. Maintenance	24,242	0	67,386	91,628	0	91,628	23,149	114,777
7. Other (specify)*	0	0	0	0	0	0	2,605	2,605
8. Total General Services	466,274	196,879	217,165	880,318	0	880,318	12,836	893,154
9. Medical Director	0	0	18,000	18,000	0	18,000	0	18,000
10. Nursing & Medical Records	1,931,215	90,952	11,650	2,033,817	0	2,033,817	30,432	2,064,249
10a. Therapy	0	0	525,336	525,336	0	525,336	0	525,336
11. Activities	165,139	10,853	3,761	179,753	0	179,753	0	179,753
12. Social Services	27,465	0	2,302	29,767	0	29,767	0	29,767
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	3,680	3,680
16. Total Health Care & Programs	2,123,819	101,805	561,049	2,786,673	0	2,786,673	34,112	2,820,785
17. Administrative	100,395	0	529,552	629,947	0	629,947	-478,334	151,613
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	45,089	45,089	0	45,089	6,115	51,204
20. Fees, Subscriptions & Promotion	0	0	14,365	14,365	0	14,365	-53	14,312
21. Clerical & General Office	171,130	27,688	12,538	211,356	0	211,356	143,744	355,100
22. Employee Benefits & Payroll	0	0	385,686	385,686	0	385,686	7,402	393,088
23. Inservice Training & Education	0	0	1,880	1,880	0	1,880	0	1,880
24. Travel and Seminar	0	0	1,812	1,812	0	1,812	1,966	3,778
25. Other Admin. Staff Trans	0	0	337	337	0	337	5,056	5,393
26. Insurance-Prop.Liab.Malpractice	0	0	135,246	135,246	0	135,246	2,251	137,497
27. Other (specify)*	0	0	0	0	0	0	22,199	22,199
28. Total General Adminis	271,525	27,688	1,126,505	1,425,718	0	1,425,718	-289,654	1,136,064
29. Total General Administrative	2,861,618	326,372	1,904,719	5,092,709	0	5,092,709	-242,706	4,850,003
30. Depreciation	0	0	37,004	37,004	0	37,004	91,463	128,467
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	1,072	1,072	0	1,072	164,994	166,066
33. Real Estate	0	0	0	0	0	0	215,693	215,693
34. Rent - Facility & Grounds	0	0	811,011	811,011	0	811,011	-810,285	726
35. Rent - Equipment & Vehicles	0	0	3,157	3,157	0	3,157	1,531	4,688
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	852,244	852,244	0	852,244	-336,604	515,640
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	185,628	0	185,628	0	185,628	0	185,628
40. Barber and Beauty Shop	0	0	22,732	22,732	0	22,732	0	22,732
41. Coffee and Gift Shops	0	0	5,705	5,705	0	5,705	0	5,705
42. Provider Participation	0	0	59,842	59,842	0	59,842	0	59,842
43. Other (specify):*	0	0	200,168	200,168	0	200,168	-200,168	0
44. Total Special Cost Ce	0	185,628	288,447	474,075	0	474,075	-200,168	273,907
45. Grand Total	2,861,618	512,000	3,045,410	6,419,028	0	6,419,028	-779,478	5,639,550

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	185,665	322,938
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	682,952	682,952
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	87,624	87,624
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	64,041
10. Total current assets	956,241	1,157,555
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	3,993	3,993
13. Land	0	508,605
14. Buildings, at Historical Cost	0	2,664,349
15. Leasehold Improvements, Historical Cost	287,017	411,165
16. Equipment, at Historical Cost	187,707	525,454
17. Accumulated Depreciation (book methods)	-235,668	-1,473,193
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	6,232	1,284,413
23. other (specify):	0	24,871
24. Total Long-Term Assets	249,281	3,949,657
25. Total Assets	1,205,522	5,107,212
CURRENT LIABILITIES		
26. Accounts Payable	233,768	233,768
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	100,000	1,430,000
30. Accrued Salaries Payable	274,024	274,024
31. Accrued Taxes Payable	1,329	1,329
32. Accrued Real Estate Taxes	0	216,000
33. Accrued Interest Payable	0	13,924
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	152,264	69,868
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	761,385	2,238,913
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	2,475,454
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	2,475,454
46.Total Liabilities	761,385	4,714,367
47.Total Equity	444,137	392,845
48.Total Liabilities and Equity	1,205,522	5,107,212

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	6,138,474
2. Discounts and Allowances for all Levels	-561,952
Subtotal - Inpatient Care	5,576,522
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	955,008
7. Oxygen	3,031
Subtotal - Anciliary Revenue	958,039
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	2,922
13. Barber and Beauty Care	27,414
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	14
16. Rental of Facility Space	0
17. Sale of Drugs	262,288
18. Sale of Supplies to Non-Patients	0
19. Laboratory	18,852
20. Radiologyand X-Ray	10,977
21. Other Medical Services	75,328
22. Laundry	7,475
Subtotal - Other Operating Revenue	405,270
24. Contributions	0
25. Interest and Other Investments Income	7,254
Subtotal - Non-Operating Revenue	7,254
27. Other Revenue (specify):	0
28. Other Revenue (specify):	683
Subtotal - Other Revenue	683
30. Total Revenue	6,947,768
31. General Services	880,318
32. Health Care	2,786,673
33. General Administration	1,425,718
34. Ownership	852,244
35. Special Cost Centers	414,233
35. Provider Participation Fee	59,842
37. Other	0
40. Total Expenses	6,419,028
41. Income Before Income Taxes	528,740
42. Income Taxes	0
43. Net Income or Loss for the Year	528,740

Page